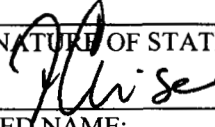
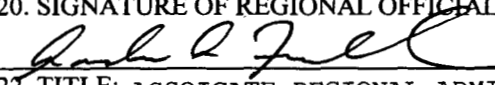


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: <div style="text-align: center;">04-04</div>	2. STATE <div style="text-align: center;">Louisiana</div>
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <div style="text-align: center;">February 2, 2004</div>	
5. TYPE OF PLAN MATERIAL (Check One): <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT </div>			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 430.12(b)		7. FEDERAL BUDGET IMPACT: a. FFY <u>2004</u> \$0.00 b. FFY <u>2005</u> \$0.00	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Pre-Print Page 89		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Same (TN 98-04)	
10. SUBJECT OF AMENDMENT: The purpose of this amendment is to designate Frederick P. Cerise, M.D., M.P.H. as the person authorized to sign Form 179 to submit changes to the Medicaid State Plan.			
11. GOVERNOR'S REVIEW (Check One): <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL </div> <div> <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: The Governor does not review state plan material. </div> </div>			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: State of Louisiana Department of Health and Hospitals 1201 Capitol Access Road PO Box 91030 Baton Rouge, LA 70821-9030	
13. TYPED NAME: Frederick P. Cerise, M.D., M.P.H.			
14. TITLE: Secretary			
15. DATE SUBMITTED: March 5, 2004			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: <div style="text-align: center;">18 MARCH 2004</div>		18. DATE APPROVED: <div style="text-align: center;">25 MARCH 2004</div>	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <div style="text-align: center;">2 FEBRUARY 2004</div>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: <div style="text-align: center;">ANDREW A. FREDRICKSON</div>		22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR <div style="text-align: center;">DIV OF MEDICAID & CHILDREN'S HEALTH</div>	
23. REMARKS:			

Revision: HCFA-PM-97-4
AUGUST 1991

(BPD)

OMB No. 0938-

State/Territory: LOUISIANA

Citation7.4 State Governor's Review

42 CFR 430.12(b)

The Medicaid agency will provide the opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Health Care Financing Administration with such documents.

☒ Not applicable. The Governor- -

☒ Does not wish to review state plan material.

☐ Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

DEPARTMENT OF HEALTH AND HOSPITALS

(Designated Single State Agency)

Date: 2/2/2004

STATE <u>Louisiana</u>	A
DATE REC'D <u>18 Mar 2004</u>	
DATE APP'VD <u>25 Mar 2004</u>	
DATE EFF <u>2 Feb 2004</u>	
HCFA 179 <u>04-04</u>	


(Signature)

SECRETARY
(Title)

TN# 04-04 Approval Date 25 Mar 04 Effective Date 2 Feb 04
Supersedes
TN# 98-04

SUPERSEDES TN- 98-04